ROYAL
PHARMACEUTICAL
SOCIETY

Keeping patients safe when they transfer between care providers – getting the medicines right

Final report

June 2012

1. Introduction

There is a substantial body of evidence that shows when patients move between care providers the risk of miscommunication and unintended changes to medicines remain a significant problem.

In 2010 an audit across 50 acute trusts involving over 8600 patients found that when medicines were checked after admission most patients had at least one omitted drug or wrong dose[1]. Earlier estimates suggest that between 30 and 70% of patients have either an error or an unintentional change to their medicines when their care is transferred[2].

On an individual basis, this is illustrated frequently through untoward incidents reported through the National Reporting and Learning System.

The likelihood that an elderly medical patient will be discharged on the same medicines that they were admitted on is less than 10%[3]. Between 28-40% of medicines are discontinued during hospitalisation[4] and 45% of medicines prescribed at discharge are new medicines[5]. 60% of patients have 3 or more medicines changed during their hospital stay[6].

Adverse drug events occur in up to 20% of patients after discharge and it is estimated that 11-22% of hospitalisations for exacerbations of chronic disease are a direct result of non-compliance with medication[7].

One study estimated that risk of an adverse drug event post-discharge increased by 4.4% for every drug alteration or change[8].

It is the responsibility of all the professionals involved in the care of a patient to ensure the safe transfer of information about their medicines. However, this can be challenging as patients often follow complex pathways, with multiple healthcare professionals involved. Systems and processes also vary significantly from organisation to organisation.

As the NHS enters a new phase of re-structuring in England, with Clinical Commissioning Groups (CCGs) taking over the commissioning of services from Primary Care Trusts (PCTs) and the move towards encouraging new providers, there is an opportunity and a need to re-emphasise the importance of ensuring that information about medicines is effectively transferred when care moves from one provider to another.

Improving the transfer of information about medicines **across all care settings** should help to reduce incidents of avoidable harm to patients, improving patient safety and contributing to a reduction in avoidable medicines related admissions and readmissions to hospital. This provides a clear link to the Quality, Innovation, Productivity and Prevention (QIPP) programme and the NHS outcomes framework. With this in mind, the then two National Clinical Directors for Pharmacy asked the Royal Pharmaceutical Society to lead a multidisciplinary project to consider how best to support the commissioning and provision of services involving the transfer of information about medicines.

1. Dodds LJ. Unintended discrepancies between pre-admission and admission prescriptions identified by pharmacy-led medicines reconciliation: results of a collaborative service evaluation across East and SE England. IJPP 18 (Supp 2) September 2010 pp9-10
2. National Patient Safety Agency and National Institute for Health and Clinical Excellence. Technical safety solutions, medicines reconciliation. 2007 **www.guidance.nice.org.uk/PSG001**
3. Relationship of in-hospital medication modifications of elderly patients to post discharge medications, adherence and mortality. Ann Pharmacotherapy 2008; 42: 783-9
4. Health care system vulnerabilities: understanding the root causes of patient harm. Am J Health Syst Pharm 2012; 69: 43-5
5. What happens to long-term medication when general practice patients are referred to hospital? Eur J Clin Pharmacol 1996; 50: 253-7
6. Drug changes at the interface between primary and secondary care. Int J Clin Pharmacol Ther. 2004; 42:103-9
7. Health care system vulnerabilities: understanding the root causes of patient harm. Am J Health Syst Pharm 2012; 69: 43-5
8. Adverse drug events due to discontinuations in drug use and dose changes in patients transferred between acute and long-term care facilities. Ann Intern Med 2004; 164: 545-50

2. Project aims

The project had three main aims

- To encourage healthcare professionals to take personal responsibility for the transfer of information about medicines. The project was led by the Royal Pharmaceutical Society with input from other professional Royal Colleges to raise awareness about the purpose and need for consistent transfer of information.
- To provide a common data set for the improvement and development of organisational systems and processes to support the safe transfer of information about patients' medicines. The data set can be incorporated into electronic or paper based systems for transferring medicines information. It can also provide the basis for auditing the quality of information transfer.
- To engage with patients through patient groups and NHS Choices to encourage them to take an active role in understanding their medicines to improve their safe management when they move between care providers.

3. Guidance developed

The project developed **core principles** to underpin the safe transfer of information about medicines whenever a patient transfers care providers, at any point in the care pathway.

These multi-professional principles can be used by:

- professional bodies to promote good practice;
- providers to help design safe services;
- commissioners to incorporate within service specifications;
- patients and patient groups to help actively involve patients in managing their medicines when they transfer care settings.

In addition, **recommended core content** of records was developed for the information about medicines that should be transferred when patients move from one care provider to another.

The principles and core content were supported by **organisational guidance** to help commissioner and provider organisations integrate effective transfer of information about medicines into their services.

A **patient fact sheet** was developed for patients, patient groups and the public to help raise awareness and actively involve patients in managing their medicines when they move care settings. This was supported by a video for patients to improve their understanding of issues around transfer of care and a media launch helped to raise awareness amongst the public and patients.

The guidance documents can be found at the back of this report in Appendices 2-4.

THIRTY THREE ORGANISATIONS RANGING FROM ACUTE HOSPITALS THROUGH TO COMMUNITY SERVICES, CARE HOMES AND PATIENT SUPPORT ORGANISATIONS VOLUNTEERED TO PUT THIS GUIDANCE INTO PRACTICE LOCALLY. SEE THE EARLY ADOPTER PROGRAMME, SECTION 7

4. Development process

Initial project scoping comprised a literature review of the extent of the problem and the various initiatives that had been undertaken previously to improve information transfer. A multi-professional stakeholder working group refined the scope and gave focus to the project.

Principles for healthcare professionals and organisations, and core content for medicines transfer records were drafted based on the literature review, existing guidance and input from healthcare professionals. The drafts were refined and developed through multidisciplinary user groups and a patient group for applicability across patient groups and medical specialities.

The draft was circulated to commissioners, providers, professional bodies (including IT committees), National Clinical Directors and patient groups for comment.

Multidisciplinary user group testing refined the support tools and resources required to implement the guidance and identified early adopter sites to be part of a six month improvement initiative (see section 7).

Details of the contributors to the development process can be found at **www.rpharms.com/toc**.

5. Involvement of other professions and patients

Throughout the development of the guidance there was strong engagement across key stakeholders including professionals and patients. The three Chief Professional Officers at the time (Professor Sir Bruce Keogh, Dr Keith Ridge and Dame Christine Beasley) supported the professional guidance and provided the foreword. The Royal College of General Practitioners, the Royal College of Physicians, the Royal College of Nursing and the Academy of Medical Royal Colleges endorsed the guidance for healthcare professionals.

Jim Easton, National Director for Improvement at Department of Health and Peter Rowe, National QIPP Lead for Medicines Use and Procurement provided the forward to the guidance for providers and commissioners.

The involvement of key stakeholders was ensured in a number of ways:

- Organisational representation at the stakeholder group.
- Individual meetings between RPS and the stakeholder.
- Widespread consultation.
- Involvement in the communication process to their members.

6. Dissemination and communication of guidance

The guidance and supporting implementation resources were published on the RPS website and linked to from other Royal Colleges' websites, highlighted on the front page of the DH website and reported in professional journals. In addition, the guidance was disseminated via the key stakeholders to their members, for example, the National Prescribing Centre uploaded a podcast about the guidance on their website.

The communication strategy generated the following interest:

- Twenty regional BBC and commercial radio interviews with a total listenership of over 6.5 million, with consultant pharmacist Nina Barnett and patient Ray Forsyth from Sunderland.
- Ray Forsyth also featured in the evening news bulletin on Tyne Tees TV, along with a local pharmacist.
- The Department of Health and NHS Choices both featured the campaign and its resources on their homepages, along with the Academy of Royal Medical Colleges.
- The Royal Colleges joined in with the RPS social media strategy by tweeting information about the guidance.
- There were over 3,000 page views of the Transfer of Care homepage on the **www.rpharms.com** site the week of the launch, and the patient information on **www.ipharmacist.me** received over 300 hits during the same period.
- There were over 850 unique visitors to the Transfer of Care article on the DH site.
- The video for patients received over 300 hits during the week of the launch.
- NHS Choose and Book have recommended trusts amend their patient information to include advice that people should take their medicines with them when they go into hospital.

RCGP Chair Dr Clare Gerada said of the guidance:

"The Royal College of General Practitioners welcomes this new guidance; our commitment to consistency and continuity are so important to improving and maintaining the quality of care that our patients receive, and this commitment should extend to the way we transfer information about our patients' medicines."

"Of course mistakes with medicines should not happen as patients transfer between services; this results in unnecessary hospital admissions which are extremely expensive for the NHS at a time when we all need to be aware of financial waste."

"But far, far more importantly is this impact these errors can have on the health of our patients. Healthcare professionals have the best interests of their patients at heart, but mistakes such as these, as patients transfer between services, fly in the face of the hard work clinicians do every day to improve their patients' health."

"This guidance will help improve the way healthcare professionals across the NHS communicate information about our patients' medicinal needs. Patients rightly expect the best possible quality of care from their health service, and we all have a responsibility to work together to ensure that the patient experience is the best it can be; this new guidance will help make sure that it is."

The National Institute for Health and Clinical Excellence said of the guidance:

"NICE supports the publication of the Royal Pharmaceutical Society professional guidance on transfer of care. NICE welcomes the commitment of pharmacists across all sectors to its effective implementation, which will deliver further support for key recommendations in the NICE Medicines Adherence and Medicines Reconciliation guidance."

7. The early adopter programme – delivering improvements locally

The early adopter programme was facilitated by RPS to help organisations put the guidance into practice locally. The programme encouraged a multidisciplinary approach to improving the transfer of information about medicines and involved clinicians, front-line staff, practitioners, patients and managers.

The early adopter programme provided volunteer sites with the opportunity to learn from, and build-on, existing knowledge and practice in a way that enhanced innovation and creativity. It also provided support for organisations and individuals that was sensitive to local priorities but that helped to deliver results.

Crucially the programme enabled volunteer sites, over the course of six to eight months, to share and learn from colleagues and from the other teams taking part.

7.1 The programme structure

The early adopter programme was supported by a series of three learning workshops held at month one, month three and month six of the programme:

- Workshop 1 focused on the identification of aims and objectives for each site and making sure these were measurable and could, in theory, be achieved.
- Workshop 2 focused on problem solving and the sustainability of the projects.
- Workshop 3 focused on some early learning from the sites and dissemination and spread.

Each of the workshops built on the learning from the previous event and included interactive sessions and activities; plenary presentations; skill building and better practice workshops. All of the workshops incorporated significant time for networking with colleagues from other teams in different organisations.

In addition to the workshops, webinars were available to reiterate some of the learning from the workshops and to share experiences between the sites.

Sites were able to access advice, guidance and support from colleagues in other sites and a panel of people (virtual faculty) experienced in medicines management and quality improvement.

THE EXPERTISE OF NHS ORGANISATIONS AND INDIVIDUALS SUPPORTED THE EARLY ADOPTER WORKSHOPS. THEIR INPUT IS GRATEFULLY ACKNOWLEDGED.

THE WORKSHOP PROGRAMMES AND PRESENTATIONS CAN BE FOUND ON THE RPS TRANSFER OF CARE VIRTUAL NETWORK SITE.

7.2 The sites

Thirty three sites volunteered to be part of the early adopter programme (see Appendix 1). Whilst these sites led the improvement initiative(s) locally, they were in some cases working with two or three partner organisations in their locality. The lead sites were from a range of different organisations, these included:

- Hospital trusts
- Community services trusts
- Prisons
- Community pharmacies
- Local Pharmacy Forums
- Local Pharmaceutical Committees
- Clinical Commissioning Consortium
- Primary Care Trusts
- Care Home
- Patient Group

7.3 The aims and achievements

The sites volunteering came from a range of different sectors, their aims were set locally and many of the sites had multiple aims. All the early adopter sites have completed summary reports about their improvement initiatives. The reports give details about their achievements, experiences of trying to make improvements, as well as how they intend to sustain any change and spread good practice.

Some of the sites focused on making changes to internal systems and processes, other sites worked with partners across organisations in their health community. Some examples of the sites achievements are given below. However for the detail of individual initiatives we recommend that the individual site summaries on the RPS website are reviewed at **www.rpharms.com/getting-the-medicines-right/early-adopters.asp**

Some examples of the improvements made:

- Improving the quality of discharge communications in line with RPS recommended core content of records for medicines when patients transfer care providers [Sites 3, 9, 10, 13, 15, 26, 27, 29, 31]. Several hospital trusts improved the quality of discharge communications by ensuring that medications stopped, started or changed formed part of the discharge summary. This was achieved through a variety of interventions, such as: the inclusion of mandatory fields in electronic discharge summaries, in-patient chart re-design to increase the emphasis on changes to medications and in-patient training of ward and clinical teams.
- Prisons reviewed and updated their processes to embed medicines reconciliation on arrival at the prison, and transfer of medicines information when prisoners leave. [Sites 2, 6, 17]
- Improved communication about medicines and/or medicines services directly with patients [Sites 5, 11, 13, 15, 14, 18, 23, 24, 26, 28] for example, through patient held medication records, patient information leaflets, training of pharmacy team members to improve and target counselling interventions, patient medication records.
- Improved communication in specific patient groups where accurate and timely communication is particularly important and/or is historically poor [Sites 3, 19, 21, 22, 27]. For example in people with Parkinson's disease, people taking warfarin, those on secondary osteoprotection, people with diabetes or people taking high risk medications such as lithium and antipsychotics.
- Identification of how best to identify and/or refer patients who would benefit from a targeted MUR post discharge to a community pharmacy. See page 8.
- A renewed focus on medicines reconciliation on admission to hospital [Sites 14, 27, 31], for example, by improving the information about medicines provided by general practice or by targeting resources more effectively on admissions wards.
- Using the green bag on discharge as a way of ensuring that all medicines and medicines information are sent home, or to the relevant care setting, with the patient [Site 32].
- Improved engagement and communication about medicines with care homes [Sites 7, 14], and between hospital and primary care (community pharmacies and general practice) [Sites 8, 20, 21].

See Appendix 1 for a list of the sites and contact details

TRANSFER OF INFORMATION ABOUT MEDICINES FROM HOSPITALS TO COMMUNITY PHARMACIES. EXPERIENCES FROM THE EARLY ADOPTER SITES

Twelve of the early adopter sites used the introduction of the targeted Medicines Use Review (tMUR) services in England to encourage patients to attend a community pharmacy for a post discharge MUR. In some cases the hospital was the lead site in the initiative, in other cases community pharmacies, the Local Pharmaceutical Committee (LPC) or the Local Pharmacy/Practice Forum (LPF) took the lead.

The early adopter sites used a variety of approaches to encourage patients to visit a community pharmacy for a post discharge MUR. These ranged from piloting the initiative on specific wards with specific patient groups, through to blanket inclusion of a patient information leaflet in all bags of discharge medications, and a range of approaches in between. Some sites targeted patients using direct contact with a healthcare professional to explain the benefit of a post discharge MUR, several sites also provided patients with a copy of their discharge summary to take to their community pharmacy.

The sites listed opposite had at least one of their aims to encourage uptake of the post discharge MUR. Details about all their achievements and experiences can be found in the site summaries on the RPS website at **www.rpharms.com/toc** along with relevant contact details.

- Birmingham and Solihull LPF
- Brighton and Sussex University Hospitals NHS Trust
- Croydon Borough Team
- East Lancashire Hospitals NHS Trust
- Heatherwood and Wexham Park Foundation Trust
- Hertfordshire LPC
- Leeds Teaching Hospitals Trust
- Norfolk and Norwich University Hospital
- North Bristol NHS Trust
- North Staffordshire LPC
- Northumbria Healthcare
- University Hospitals Bristol NHS Foundation Trust

7.4 Tips from the early adopter sites

The aims of the early adopter sites were locally driven and so differ from each other. However the experiences of the sites generated some learning that can be utilised by other organisations wanting to undertake their own improvement initiatives.

■ GET BUY-IN FROM PEOPLE DELIVERING THE CHANGE

Where an improvement initiative requires changes to existing practice not only does there need to be managerial commitment from all organisations involved, but this needs to be effectively communicated to the healthcare professionals on the ground who will affect the change.

■ UNDERSTAND YOUR LOCAL ENVIRONMENT

Securing agreement for change can take time, especially in larger organisations where multiple clinical specialities are involved. Other local factors such as lack of capacity, priority being given to other initiatives, changes to key personnel can lead to delays and the need to revisit timescales or redefine projects.

■ YOU MAY START IN ONE PLACE AND FINISH IN ANOTHER

You may need to modify your aims as a result of initial work on the improvement initiative. For example, a review of systems may lead to the identification of underlying problems that need to be addressed, or initial aims may be broken down into smaller pieces of work.

■ AUDIT WHAT YOU ARE DOING

Monitor interventions to ensure that you are actually making improvements. It may be that the outcome you intended was not being achieved, or that the input necessary to affect a relatively small change is not sustainable.

■ LEARN FROM EACH OTHER

Making the time and giving yourself the opportunity to talk to other organisations making changes to their practices will help you to develop your own ideas about how best to drive improvement locally. The NHS has a wide range of resources available on improvement initiatives through the NHS Institute at **www.institute.nhs.uk**

■ WORK OUT HOW TECHNOLOGY CAN HELP

Technology can be successfully utilised to embed better transfer of information about medicines into systems and processes. However it can also be a barrier to progress, for example where existing IT systems are in place there can be resistance to change or update them, or incompatibilities between systems in different organisations need resolution.

8. Conclusion

The success of the project was largely due to the strength of our engagement strategy; with other Royal Colleges and professional bodies, patients and patient groups, and healthcare professionals from across a range of different settings and professions. At the same time, the project linked to other national initiatives and levers to ensure maximum impact. The network of early adopters ensured implementation across different settings and the programme gave the sites access to a virtual faculty of experts and time and space for peer support and problem solving through structured workshops.

9. RPS Recommendations

FOLLOWING FEEDBACK FROM THE EARLY ADOPTER PROGRAMME, THE RPS CALLS FOR THE FOLLOWING:

- All suppliers of IT systems to hospitals and general practice should ensure that their systems are able to effectively transfer the recommended core content of records for medicines.
- All community pharmacies should have an **NHS.net** website address to enable secure communications between secondary and primary care.
- Going forward, all clinical records should be structured in a recognised and nationally agreed format to assist interoperability and the transfer of information.
- The most effective ways of signposting patients treated in secondary care to the post discharge Medicines Use Review Service and New Medicine Service offered by community pharmacists should be shared nationally to ensure that patients are able to optimise their outcomes from medicines.
- The early adopter sites identified that a subgroup of patients likely to benefit from a post discharge MUR are unable to benefit from the service as they cannot get to a community pharmacy (for example patients in care homes or those who are housebound). Commissioning of such services to these vulnerable patients should be considered as part of the pharmacy contractual frameworks.

Appendix 1. The early adopter sites

ORGANISATION	CONTACT
1. Age UK	Alexandra Rogacewicz, alexandra.rogacewicz@ageuk.org.uk
2. Bedfordshire Community Health Services and HMP Bedford	Trevor Jenkins, trevor.jenkins@bedfordshire.nhs.uk
3. Berkshire Healthcare NHS Foundation Trust	Kiran Hewit, kiran.hewitt@berkshire.nhs.uk
4. Birmingham and Solihull LPF	Minesh Parbat, minesh.parbat@nhs.net
5. Brighton and Sussex University Hospitals NHS Trust	Fleur Baylis, fleur.baylis@bsuh.nhs.uk
6. Bristol Community Health	Cathy Cooke, cathy.cooke@nhs.net
7. BUPA Care Homes	Paula Keys, paula.keys@bupa.com
8. Cardiff and Vale Local Pharmacy Practice Forum	Darrell Baker, darrell.baker@wales.nhs.uk
9. Central Manchester University Hospitals	Rebecca Morgan, rebecca.morgan@uhsm.nhs.uk
10. Colchester Hospital University Foundation Trust	Anne Regan, anne.regan@colchesterhospital.nhs.uk
11. Croydon Borough Team	Eileen Callaghan, eileen.callaghan@croydonpct.nhs.uk
12. Doncaster Adult Social Services	Kath Lindley, kath.lindley@doncaster.gov.uk
13. East Lancashire Hospitals NHS Trusts	Alistair Gray, alistair.gray@elht.nhs.uk
14. Gateshead Clinical Commissioning Group	Catherine Armstrong, catherine.armstrong@pharmicus.org
15. Heatherwood and Wexham Park Foundation Trust	Shelan Karim, shelankarim@hotmail.com
16. Hertfordshire LPC	Lisa Olins, lisa@hertslpc.org.uk
17. HMP Wormwood Scrubs	Gideon Lund, gideon.lund@clch.nhs.uk
18. Imperial College Healthcare NHS Trust	Kandarp Thakkar, kandarp.thakkar@imperial.nhs.uk
19. Leeds Teaching Hospitals	Louise Dunsmure, louise_dunsmure@hotmail.com
20. Lloyds pharmacy	Sanjeev Kaushal, sanjeev.kaushal@lloydspharmacy.co.uk
21. Manichem Ltd	Roopa Arora, bullbrook.manichem@npanet.co.uk
22. Norfolk and Norwich University Hospital	Clive Beech, clive.beech@nnuh.nhs.uk
23. North Bristol NHS Trust	Dilesh Khandhia, dilesh.khandhia@nbt.nhs.uk
24. North Staffordshire LPC	Tania Cork, taniacork@hotmail.co.uk
25. Northumbria Healthcare NHS Foundation Trust	Richard Copeland, richard.copeland@nhct.nhs.uk
26. Nottingham University Hospitals NHS Trust	Adriece Al-Rifai, adriece.alrifai@nuh.nhs.uk
27. Peterborough and Stamford Hospital NHS Foundation Trust	Shabnum Mavani, shabnum.mavani@pbh-tr.nhs.uk
28. Poole Hospital NHS Foundation Trust	Rachael Lemon, rachael.lemon@poole.nhs.uk
29. Royal Derby Hospital	Pardeep Chera, pchera@nhs.net
30. Royal United Hospital Bath	Matt Brindley, matt.brindley@nhs.net
31. Southend University Hospital NHS Foundation Trust	Richard Ketley, richard.ketley@southend.nhs.uk
32. Surrey Community Health	Fay Boyett, fay.boyett@nhs.net
33. University Hospitals Bristol NHS Foundation Trust	Kevin Gibbs, kevin.gibbs@uhbristol.nhs.uk

For a more detailed report from each of the early adopter sites please go to **www.rpharms.com/getting-the-medicines-right/early-adopters.asp**

Appendix 2. Good practice guidance for healthcare professionals

Foreword

Taking a medicine is the most frequent intervention that patients will use to improve their health. In particular, older people and those with long term conditions rely heavily on medicines as a way of managing their illnesses. These patients, often taking multiple and complex regimens are some of the most vulnerable to problems with their medicines when they transfer care settings. Whether it's from care homes or primary care to hospitals, or mental health hospitals to the community, or from hospitals back to primary care, these are times when the risk of things going wrong tends to increase.

Research has consistently shown that there is a significant risk that patients' medicines will be unintentionally altered when they move care settings. A recent study found that when patients are admitted to hospital most are likely to have at least one omitted medicine or wrong dose.

The vast majority of us, doctors, nurses, pharmacists and other health and care professionals will be able to recall incidents where this has caused at least, inconvenience and worry, and at worst, harm to our patients.

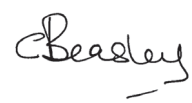
It is the responsibility of all the professionals involved in the care of a patient to ensure the safe transfer of information about their medicines. To be effective, this can only be done both with the patient's needs firmly at the centre of our intentions and through professionalism and collaboration across professions.

This can be challenging. Patients often follow complex pathways, with multiple healthcare professionals involved in the transfer process. Systems and processes also vary from organisation to organisation. These complexities often mean that, despite our best intentions, as professionals we can forget how important our handover of information, or lack of it, can be.

Practically, what we can all do as a starting point is ensure that the core information identified in this guidance forms part of all our transfer records and is available to the patient, and the next healthcare professional taking over the care of the patient, at the time it is needed.

The core principles and responsibilities in this guidance provide an overarching framework that challenges us, and our organisations, to see this as our responsibility and to act on it as a priority in order to better serve our patients.

PROFESSOR SIR BRUCE KEOGH
NHS Medical Director
Department of Health



DAME CHRISTINE BEASLEY
Chief Nursing Officer
Department of Health

DR KEITH RIDGE
Chief Pharmaceutical Officer
Department of Health

1. Introduction

THE EXTENT OF THE PROBLEM

- It is widely accepted that when patients move between care providers the risk of miscommunication and unintended changes to medications is a significant problem.
- Between 30 and 70% of patients have either an error or an unintentional change to their medicines when their care is transferred (1).
- Incidents of avoidable harm to patients can result in unnecessary readmissions (around four to five percent of hospital admissions are due to preventable problems with medicines) (2).
- And in some cases the impact on patients can be devastating.

A patient prescribed a regular weekly dose of an oral cytotoxic medicine in hospital was transferred to an intermediate care unit prior to being transferred home. The patient continued to receive their weekly dose of cytotoxic while they were receiving intermediate care. A breakdown in the transfer of information about the patient's medicines led to the patient being prescribed a daily dose of medication when they returned home. The patient was admitted acutely ill with severe anaemia after 13 days of the overdosed medication. The patient died three weeks later.

Serious Untoward Incident Report

THE SCOPE OF THIS GUIDANCE

- To protect their patients, **professionals who prescribe, and those who create and update patients' records, must take responsibility** for the safe and accurate transfer of information about medicines.
- Organisations that commission and provide services to NHS patients **must have systems and processes in place** to support the safe and effective transfer of information about patients' medicines.
- This *multidisciplinary* good practice guidance contains high level **core principles** and **responsibilities** that underpin the safe transfer of information about medicines whenever a patient transfers care providers, at any point in the care pathway.
- This includes when patients move between organisations, for example, from hospital to hospice, or care home to hospital and also when patients are under the care of multiple professionals in different locations, for example, seeing specialists on an outpatient basis, or visiting walk-in centres or community pharmacies.
- Many of the principles in this guidance will also apply to the transfer of patients within an organisation (handover). NHS Connecting for Health is currently developing core content for all types of handover as a professional and information standard.
- To support implementation of the core principles and responsibilities, recommended core content for records has been developed outlining **information about medicines that should be transferred** when patients move from one care provider to another.
- Whilst not in the scope of this guidance, there is a clear need to ensure that, along with the transfer of information, safe systems are also in place for ensuring that a patient has, or is able to access, a supply of medicines.

THIS GUIDANCE GIVES HEALTH AND SOCIAL CARE PROFESSIONALS A COMMON FRAMEWORK AND CLEAR EXPECTATIONS CONCERNING GOOD PRACTICE AROUND THE TRANSFER OF INFORMATION ABOUT MEDICINES.

JONATHAN MASON, NATIONAL CLINICAL DIRECTOR FOR PHARMACY

THE DEVELOPMENT PROCESS

- This good practice guidance has been **developed in collaboration** with pharmacy, medical, nursing and allied health professional bodies, plus national agencies, patients, patient groups, and health and social care professionals.
- The development process included a review of current national and professional guidance, and ongoing related work streams. In addition, **over 150 healthcare professionals and patients have contributed to the development of this guidance**. Their names can be found on the RPS website **www.rpharms.com/toc**. The development process is outlined in appendix 1.

A patient was admitted to hospital at six o'clock in the evening. It was known that she was prescribed insulin, but the frequency and the dose were not known. Her care home was contacted but, since her insulin was administered by the district nurse, they had no record of the dose. The following morning, the GP was contacted. He told the ward to contact the district nursing team at his surgery. The ward staff received the information about dosage and frequency at ten o'clock in the morning. The patient received her insulin at ten thirty after the ward doctor had written the prescription. This was two and a half hours past the normal dosage time.
Incident report from the National Reporting and Learning System

2. Core principles and responsibilities

- These core principles and responsibilities have been developed to underpin the safe transfer of information about medicines **whenever a patient transfers care providers**, at any point in the care pathway.
- The principles and responsibilities are intended to **encourage a culture that supports the safe and effective transfer of information** about patients' medicines.
- The **four core principles** should **underpin the practice of all health and social care professionals**. As such they need to be embedded in professional good practice guidance.
- In addition they should be **incorporated into under- and postgraduate education** programmes for all professions.
- The principles and responsibilities **provide a starting point** for all health and social care organisations and professionals to improve patient safety and avoid medicines errors as patients move. By, for example:
  - Ensuring organisational processes that underpin the safe transfer of information about medicines are consistent with the core principles and responsibilities.
  - Embedding the core principles and responsibilities in both national and local commissioning frameworks.
- More detailed information about **how the principles and responsibilities can be developed locally,** and links to early adopter organisations who are putting the principles and responsibilities into practice can be found in **part 2 of this guidance www.rpharms.com/toc**.

In 2010 an audit across 50 acute trusts involving over 8600 patients found that when medicines were checked after admission (medicines reconciliation) most patients had at least one omitted drug or wrong dose. Follow up work has shown that patients taking several medicines for long term conditions were most likely to have errors (3).

Four CORE PRINCIPLES for health care professionals

1. Health care professionals transferring a patient should ensure that all necessary information about the patient's medicines is accurately recorded and transferred with the patient, and that responsibility for ongoing prescribing is clear.
2. When taking over the care of a patient, the healthcare professional responsible should check that information about the patient's medicines has been accurately received, recorded and acted upon.
3. Patients (or their parents, carers or advocates) should be encouraged to be active partners in managing their medicines when they move, and know in plain terms why, when and what medicines they are taking.
4. Information about patients' medicines should be communicated in a way which is timely, clear, unambiguous and legible; ideally generated and/or transferred electronically.

LISTENING TO PATIENTS IS CENTRAL TO PROTECTING THEIR SAFETY. WE SEE CASES WHERE CARERS, RELATIVES OR PATIENTS HAVE QUERIED WHETHER THEY HAD THE RIGHT MEDICINES BUT NO-ONE LISTENED TO THEM.

ACTION AGAINST MEDICAL ACCIDENTS

Three key RESPONSIBILITIES for organisations providing care

- Provider organisations must ensure that they have safe systems that define roles and responsibilities within the organisation, and ensure that healthcare professionals are supported to transfer information about medicines accurately.
- Systems should focus on improving patient safety and patient outcomes. Organisations should consistently monitor and audit how effectively they transfer information about medicines.
- Good and poor practice in the transfer of medicines should be shared to improve systems and encourage a safety culture.

WHEN THEY COME BACK TO US FROM HOSPITAL, WE OFTEN DON'T KNOW WHAT MEDICINES OUR RESIDENTS ARE ON, AND WE CAN'T FIND ANYONE TO ASK.

CARE HOME NURSE

Care home managers report that around 40% of staff time is spent on aspects of medicines management.

CHUMS report into medication safety in care homes (4)

3. Recommended core content of records for medicines when patients transfer

- The content of records for medicines transfer outlined here describes the recommended core information that healthcare professionals should have access to **when a patient** arrives in their care setting.
- Healthcare professionals transferring the patient should ensure that, the core information is communicated when the patient moves between care providers.
- Since the content represents the core information that should be routinely available. It is likely that professionals and organisations will develop content further for specific patient groups, for example, for children, for patients with eye disease and/or for individual transfer settings.
- The information in these records should (and may already) be incorporated into local transfer arrangements. For example, contained as part of electronic discharge summaries, incorporated into referral letters, as part of documentation available for pre-admission clinics. Part 2 of this guidance gives examples of how commissioner and provider organisations can put this into practice **www.rpharms.com/toc**.
- The content of these records applies equally to information transferred by paper systems, generated electronically, and/or transferred electronically.
- The content and structure outlined here is broadly consistent with the Academy of Medical Royal Colleges record standards for the structure and content of medical records and communications (6,7). The recommended core content has been mapped to discharge summary headings (7) **HOWEVER** the majority of the core content will be equally relevant for other transfer settings.
- It is recognised that there is a wide range of ongoing work to support the electronic generation and transfer of medical records and in the longer term, further iterations of this content may be necessary. The RPS endorses the Royal College of Physicians vision for patient focused records accessible whatever the setting or context **www.rcplondon.ac.uk/policy/improving-healthcare/health-informatics**.

IN MY EXPERIENCE WORKING ON ADMISSIONS WARDS … IF IMPLEMENTED THIS GUIDANCE WOULD REPRESENT A VAST IMPROVEMENT IN THE QUALITY AND QUANTITY OF INFORMATION CURRENTLY TRANSFERRED.

PHARMACY TECHNICIAN – ADMISSIONS WARD

BOX 1: RECOMMENDED CORE CONTENT OF RECORDS FOR MEDICINES WHEN PATIENTS TRANSFER CARE PROVIDERS

(Shown mapped to discharge summary headings, however, content can be mapped to other transfers, for example, general practice to hospital, outpatients to general practice etc)

PATIENT DETAILS*	Last name, first name, date of birth, NHS number, patient address
GP DETAILS*	GP/Practice name
OTHER RELEVANT CONTACTS DEFINED BY THE PATIENT	For example: ■ Consultant name; Usual community pharmacist; Specialist nurse
ALLERGIES*	Allergies or adverse reactions to medicines ■ Causative medicine ■ Brief description of reaction ■ Probability of occurrence
MEDICATIONS*	Current medicines ■ Medicine – generic name and brand (where relevant) ■ Reason for medication (where known) ■ Form ■ Dose strength ■ Dose frequency/time ■ Route
MEDICATION CHANGES*	Medication started, stopped or dosage changed, and reason for change
MEDICATION RECOMMENDATIONS*	Allows for: ■ Suggestions about duration and/or review, ongoing monitoring requirements, advice on starting, discontinuing, or changing medicines. ■ Requirements for adherence support, for example, compliance aids, prompts and packaging requirements. ■ Additional information about specific medicines, for example, brand name or Special product where bioavailability or formulation issues
INFORMATION GIVEN TO THE PATIENT AND/OR AUTHORISED REPRESENTATIVE*	If additional information supplied to the patient/authorised representative on transfer. For example: ■ patient advised to visit community pharmacist post discharge for a medicines use review (MUR) ■ where capacity, sensory or language barriers, how all necessary support information has been given to authorised representative/carer
PERSON COMPLETING RECORD*	Name, time, date, job title Contact telephone number for queries Signature (if paper based)

**Headings consistent with the Academy of Medical Royal Colleges anchor heading standards for medical records on discharge.*

4. Development process

The development process for the guidance is highlighted below. The names of over 150 organisations and individuals who have contributed to the project are listed on the RPS website **www.rpharms.com/toc**; their input and support is gratefully acknowledged.

SCOPING

Literature review.

Stakeholder working group scoping meeting.

Interviews and follow-up.

DRAFT AND DEVELOP

Principles and core content for medicines transfer record drafted.

Drafts refined and developed through multidisciplinary user groups.

Patient group to test drafts.

CONSULTATION

Wide circulation to commissioners, providers, professional bodies and patient groups for comment.

USER TESTING

Multidisciplinary user group testing.

Drafts refined and recirculated

Early adopter sites identified.

SIGN-OFF, PUBLICATION AND LAUNCH

Stakeholder working group and steering group agree final drafts.

Published on RPS website.

Multidisciplinary and patient launch events/publications.

EARLY ADOPTER SITES

Putting the guidance into practice in a sustainable way (within existing resources).

Diverse sites utilising good practice guidance over six months.

Facilitated by RPS with support from partner organisations.

Feedback and sharing of experience through RPS website.

5. References

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Appendix 3. A guide for all providers and commissioners of NHS services

Foreword

Research has shown time and again that there is a significant risk that patients' medicines will be unintentionally altered when they move care providers. A recent study found that when medicines are checked on admission to hospital (through medicines reconciliation) most patients are likely to have at least one omitted medicine or wrong dose.

In addition, it is estimated that five percent or more of hospital admissions are due to preventable problems with medicines.

The NHS outcomes framework has already recognised the significance of this to patient safety. All NHS providers, and commissioners of those services, are now charged with reducing harm to patients caused through medication errors.

Having safe systems in place for managing information and supply of medicines across care providers is also seen as central to safe, high quality care by the Care Quality Commission. Their essential standards on quality and safety have medicines management as one of their outcomes, and cooperation with other providers when care is transferred, as another.

As well as avoiding harm to patients, having safe systems across care settings is likely to lead to an overall reduction in avoidable medicines related admissions, including unnecessary readmissions to hospital. Clearly, this is closely linked to the delivery of Quality, Innovation, Productivity and Prevention (QIPP) programme goals.

The development of this guidance was led by the Royal Pharmaceutical Society, in collaboration with other royal colleges, patients, health and social care professionals, and is closely mapped to a range of related national initiatives and guidance. It gives organisations tools to develop their systems, and to help effect the culture change necessary in their organisations to raise this important patient safety issue higher up everyone's agenda.

All organisations, providers and commissioners, should review this guidance against their current systems and processes and identify where and how improvements can be made to existing services.

JIM EASTON
National Director for Improvement
Department of Health

PETER ROWE
National QIPP Lead for Medicines Use and Procurement
Department of Health

1. Introduction

WHY WE NEED TO TAKE ACTION

- The transfer of information about patients' medicines continues to be a significant risk to patient safety. **Between 30 and 70%** of patients can have either an error or an unintentional change to their medication when their care is transferred (1).
- Reducing medication errors causing harm has already been identified as **an improvement area in the NHS Outcomes Framework** under *Treating and caring for people in a safe environment and protecting them from avoidable harm (2)*.
- The **Health and Social Care Act 2008 (Regulated activities) Regulations 2010 require** that the registered person* must protect service users against the risks associated with the unsafe use and management of medicines, and cooperate with other providers.
- The Care Quality Commission (CQC) therefore considers that managing medicines when a patient transfers from one setting to another is central to safe, high-quality care. Effective management of medicines is a **requirement of CQCs essential standards on quality and safety** (Outcome 9) as is cooperation with other providers when care is transferred cooperation (Outcome 6) (3).
- Improving the transfer of information about medicines across all care settings should reduce incidents of avoidable harm to patients, and contribute to a **reduction in avoidable medicines related admissions and readmissions to hospita**l.
- All the above are clearly linked to the Quality, Innovation, Productivity and Prevention (**QIPP**) programme [**www.dh.gov.uk/en/Healthcare/Qualityandproductivity/index.htm**].
- As the NHS restructures, with more providers and new commissioners, the risk to patient safety related to inaccurate transfer of information about medicines is likely to increase.
- It is crucial that organisations commissioning and providing care **actively develop** safe systems that support, **and continuously improve** the safe transfer of information about medicines.

> *A patient was discharged from hospital with an increased dose of their antiepileptic medicine and a request written on the take home prescription for the GP to further increase in 2 weeks. The GP didn't receive a discharge letter and prescribed the patient's pre-admission dose. After taking this dose for about ten days the patient was readmitted with absence seizure.*
> ***Incident report from the National Reporting and Learning System***

WHAT THIS GUIDE CAN HELP WITH

- The Royal Pharmaceutical Society (RPS), has published **core principles and responsibilities**, endorsed by other professional royal colleges, that underpin the safe transfer of information about medicines whenever a patient transfers care providers, at any point in the care pathway.
- To support implementation of the core principles and responsibilities, content for transfer records has been developed. This outlines recommended **core information about medicines that should be transferred** when patients move from one care provider to another.
- The good practice guidance can be found in *Keeping patients safe when they transfer care settings – getting the medicines right. Part 1. Good practice guidance for healthcare professions* **www.rpharms.com/toc**.
- This guide (Getting the medicines right – Part 2) is for all providers and commissioners of services to NHS patients. A practical guide, it will help organisations and the people working in them to put the core principles and responsibilities into action locally.

* *"registered person" means, in respect of a regulated activity, a person who is the service provider or registered manager in respect of that activity*

2. Implications for COMMISSIONERS of services for NHS patients

The high level core principles and responsibilities, together with the recommended core information for medicines transfer records, provide a starting point **www.rpharms.com/toc**. They enable commissioners of NHS services to open discussions with providers of NHS services around the quality of information transfer about patients' medicines.

They should be viewed and used in the context of the other national, and where in place, local initiatives already developed to improve the accuracy of information about medicines and transfer arrangements in general.

SUGGESTED NEXT STEPS FOR COMMISSIONERS

- In the context of wider transfer arrangements, review how effectively provider services currently transfer information about patients' medicines.
- Review existing contracts, service level agreements, quality contracts and incentive schemes with provider services. With a view to incorporating the principles and responsibilities, and recommended core information requirements where appropriate.
- Work with provider services to agree robust, patient-focused outcome measures which can then be incorporated into commissioning arrangements.
- Monitor provider services against agreed outcomes and where necessary agree improvement measures.

SUPPORTING NATIONAL GUIDANCE

- The **Care Quality Commission** (CQC) has developed a self assessment tool for commissioners *Managing patients medicines after discharge*. Commissioners should use it to identify how to commission safer services (4).
- National Institute for Health and Clinical Excellence (**NICE**) and National Patient Safety Agency (**NPSA**) patient safety guidance recommends that all adult patients admitted to hospital have their medicines reconciled within 24 hours (1).
- Several **NPSA** alerts have already recommended immediate implementation of safe transfer systems for medicines and medicines information. These include anticoagulants (5), oral anticancer medicines (6), lithium (7), loading doses (8), and insulin (9).
- One of the DH **indicators for quality improvement in community services** is the percentage of discharge letters issued in accordance with national guideline standards (including information about medicines) (10).
- Following **CHUMS** (the care homes' use of medicines study (11)) the integrated approach to medication safety led by the National Care Association and the Health Foundation is working to improve medicines safety in care homes. A set of practical tools to help residents, doctors, pharmacists and care home staff reduce the incidence of medication errors and near misses is being developed. This will include tools to help when residents transfer care settings. See linked work streams at **www.rpharms.com/toc**
- **CQC** recommends that GPs use standard referral forms for the information that GPs will provide to local acute trusts about patients medicines (12). It also recommends that commissioners audit the quality of these forms.

HOW YOU MIGHT PUT THIS INTO PRACTICE

- Work with provider services to incorporate into the Commissioning for Quality and Innovation (CQUIN) payment framework indicators which support the effective transfer of information about medicines. Examples of potential indicators include:
  - The proportion of admitted patients who have their medicines reconciled within 24 hours of admission to hospital.
  - The percentage of discharge summaries with complete information about patients' medicines.

    PRACTICE EXAMPLE *NHS Plymouth has, with Plymouth Hospitals NHS Trust, established arrangements for a high quality electronic discharge document including detailed information about medicines. A summary of the medication-related information is also produced for the community pharmacist. Having agreed what should routinely appear in discharge information, audit was subsequently used to drive continuous improvement.*
    Contact: Oksana.Riley@nhs.net

  The NHS Institute for Innovation and Improvement website contains more examples of indicators developed by local commissioners (**www.institute.nhs.uk/world_class_commissioning/pct_portal/cquin.html**).

- Explore other options for using contracts and incentive schemes to affect culture change. For example, use of the Quality and Outcomes Framework (QOF) to incentivise GP practices to agree and develop standard templates for referral information about medicines to be supplied to local acute trusts.

  PRACTICE EXAMPLE *NHS Sheffield produced guidance on medicines reconciliation for GP practices. The guidance is for practices to help establish safe systems for receiving information about changes to patient's medicines on discharge from hospital. On initial launch, the guidance was incentivised through QOF and, overall, has been well received and implemented by practices.*
  Contact: Hilde.Storkes@nhs.net

3. Implications for PROVIDERS of services to NHS patients

Provider organisations need to consider how best to incorporate the core principles and responsibilities into organisational practice. Provider organisations should also review the content of the records used to transfer patient information against the recommended core content.

Suggested next steps for provider services

- Review current policies and procedures in line with the core principles and responsibilities.
- Review recommended core content for transfer records against current information provided.
- Audit practice in key areas to establish a baseline.
- Identify where practice requires change or improvement and identify how this might be achieved.
- Consider the implications of information governance requirements.
- Develop an organisational action plan to support a culture of continuous improvement.
- Incorporate into training and development of healthcare professionals and support staff involved in transfer of information about medicines.
- Benchmark against other similar provider services.

How you might put this into practice

- Use the annual patient experience survey to monitor and drive improvement in communication with patients about their medicines when they are discharged.
- Identify and monitor the NICE quality standards that require effective transfer of information. For example the Glaucoma Quality Standard (13).
- Develop systems to monitor the number of readmissions due to avoidable problems with medicines.
- Ensure that patients discharged from hospital who have had changes made to their medicines are aware that they can request a post-discharge medicines use review (MUR) from their community pharmacist (14). Work with community pharmacists to audit the impact of these reviews.
- Use implementation tools to help develop processes for medicines reconciliation when patients transfer to (**or back to**) your organisation. For example, the National Prescribing Centre's guide to implementing medicines reconciliation (15).
- Audit the accuracy of information about medicines that is contained in your discharge summaries. Develop processes to improve quality.
- Audit the accuracy of information about medicines contained in letters or communications from hospital out-patient clinics to GPs. Develop processes to improve quality.
- Have risk management and incident reporting systems in place to share learning and near misses.
- Review the RPS website, to see what other (early adopter) organisations are doing to put the guidance into practice.

IN A SNAPSHOT SURVEY NHS DIRECT TOOK OVER 600 CALLS IN ONE MONTH FROM CARERS WHO NEEDED HELP RESOLVING A PATIENT'S MEDICATION PROBLEM.

EXAMPLES OF LOCAL INITIATIVES TO IMPROVE INFORMATION TRANSFER

- Local teams in County Durham and Darlington, and Imperial College Healthcare NHS Trust, have developed personal patient held booklets/ passports that patients take with them when they move between care providers. **County Durham and Darlington: Labib.Tadros@cddft.nhs.uk Imperial College Healthcare NHS Trust: Kandarp.Thakkar@imperial.nhs.uk**
- East Lancashire Hospitals Trust systems were reviewed to improve the quality of the medicines information contained in discharge summaries. Improvement measures include, electronic patient tracking to identify patients requiring medicines reconciliation, re-design of Trust stationary, training, and electronic discharge summaries requiring a pharmacy check before they can be released. This means that the medicines information in the summary is an accepted quality, as agreed with commissioners as part of the hospitals quality account. **Contact: Alistair.Gray@elht.nhs.uk**
- The Welsh Ambulance Service NHS Trust has endorsed the use of GREEN bags to collect patients' own medicines. Clinical governance directives have been issued to all employees and posters promoting the GREEN bag initiative have been circulated to all GP surgeries across Wales. The bags are available centrally through Welsh Health Supplies. **Contact: chris.moore@wales.nhs.uk**
- In South Staffordshire, elderly patients recently discharged from community beds in secondary care receive domiciliary medicines use reviews from accredited community pharmacists. This has contributed to fewer re-admissions within 28 days and improvements in measures of functional independence for patients. The service is a locally commissioned enhanced service. **Contact: goldsteinruth@aol.com**
- GP practices in Gateshead have agreed a standard template for information supplied as part of referral documentation. The information is pulled directly from the practice IT system. It includes information about the patients' current medicines. The template has the backing of the LMC, commissioners and the local acute Trust. **Contact: jharness@nhs.net**

4. (Early adopter) Organisations putting the guidance into practice

- The core principles and responsibilities have been developed to provide a high level common framework against which professionals and organisations can judge themselves.
- However, patients have different diseases, can be transferred to and from a whole range of organisations, and have their care managed by different healthcare professionals.
- That means that the method for embedding the principles and responsibilities into professional and organisational practice, and how accurate transfer of the recommended core information is achieved will vary across provider organisations.
- Organisations may already be some or most of the way to implementing many of the recommendations. For the most part, this guidance should be seen as a way of helping to drive change and shift culture within existing resources in order to deliver sustainable improvements in safe medicines practice.
- To test the practical applicability of the good practice guidance and the core standards, early adopter sites will be putting the high level principles and responsibilities into practice. Links to the early adopter sites can be found on the RPS website **www.rpharms.com/toc**.

"I WAS CALLED THIS MORNING BY A PATIENT TO TELL ME THAT HER DISCHARGE MEDICINES WOULD RUN OUT IN THE EVENING.

WHEN PATIENTS ROUTINELY USE THE SAME COMMUNITY PHARMACY, IT WOULD SAVE HOURS OF TIME, AND PATIENT ANXIETY, IF THEIR PHARMACIST KNEW ABOUT CHANGES TO THEIR MEDICINES ON DISCHARGE."

COMMUNITY PHARMACIST

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Appendix 4. Patient fact sheet

HELP GET THE RIGHT MEDICINES
WHEN YOU MOVE CARE PROVIDERS

Many people take responsibility for your care every day in the NHS.
When your care is transferred from one place to another, it is important that the people looking after you know what medicines you take. Getting your medicines right in these situations can sometimes be difficult.

If you can, help the people looking after you to get your medicines right.
There are lots of things that you, or your carer, can do.

What can I (or my carer) do?

At home

- Keep a complete, **up-to-date** list of all your medicines handy. This form can help you do this. If you need help with making a list, ask a healthcare professional.
- Keep the medicines you are taking together in a safe place. Don't keep old medicines you no longer need.
- Know what medicines you are taking. If you stop taking a medicine for any reason let your doctor or pharmacist know.

When you move

- Take a list of your medicines, **and your medicines**, with you. Use a container to keep the medicines together.
- In hospital, your medicines should be checked within 24 hours of you arriving. If this doesn't happen, ask when it will be done.

When you leave

- Before you leave, ask for your medicines to be explained to you. **Especially any changes**. And ask for information to be given to you in writing (preferably printed).
- When you next see your GP check they also know about any changes.
- Ask your local pharmacist for a medicines use review (known as an MUR) to help make sure that you understand any changes fully.

Above all...

- If you are unsure about your medicines, just ask a health professional for help.

Always take this list with you when you move between care providers

Patient's name:

NHS number (where known):

My current medicines:

(Please list all medicines including inhalers, eye/ear drops, patches, injections, and alternative/herbal medicines)

Medicine	Presentation (e.g. tablet, liquid, patch)	Dose	Frequency (How often I take my medicines e.g. daily)	Additional information (e.g. What I take this medicine for)

Medicines I cannot take

Name of medicine	Reason

Notes about my medicines

You can download further copies of this form at **www.rpharms.com/toc**

About the Royal Pharmaceutical Society

The Royal Pharmaceutical Society (RPS) is the professional body for pharmacists and pharmacy in Great Britain. We represent all sectors of pharmacy in Great Britain and we lead and support the development of the pharmacy profession including the advancement of science, practice, education and knowledge in pharmacy.

In addition, we promote the profession's policies and views to a range of external stakeholders in a number of different forums.

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